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Issue Date: 22 November 2002

In the Matter of

Foster R. Addair
Claimant

v.

Robinson-Phillips Coal Company and A.T. Massey,
Employer/Carrier

and

Director, Office of Workers' Compensation Programs,
Party-In-Interest

Case No. 2001-BLA-450

DECISION AND ORDER
AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act of 1977, 30 U.S.C. Section 901 et seq. In accordance with the Act and the regulations issued thereunder, the case was referred by the Director, Office of Workers' Compensation Programs for a formal hearing.

Benefits under the Act are awardable to miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of miners who were totally disabled at the time of their deaths (for claims filed prior to January 1, 1982), or to the survivors of miners whose deaths were caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment and is commonly known as "black lung."

A formal hearing was held before the undersigned on June 26, 2002, in Pipestem, West Virginia, at which all parties were afforded full opportunity in accordance with the Rules of Practice and Procedure (29 C.F.R. Part 18) to present evidence and argument as provided in the Act and the regulations issued thereunder, set forth in Title 20, Code of Federal Regulations, Parts 410, 718, 725, and 727. The Claimant filed a brief on July 30, 2002, and the Employer filed

a brief on October 29, 2002. The Director did not file a brief.

I have based my analysis on the entire record, including the transcript, exhibits, and representations of the parties, and given consideration to the applicable statutory provisions, regulations, and case law, and made the following findings of fact and conclusions of law.

JURISDICTION AND PROCEDURAL HISTORY

The Claimant, Foster Addair, filed a claim for benefits on January 7, 1998 (DX 1), and on October 28, 1998, the District Director made an initial determination that the Claimant was eligible for benefits (DX 20). The Employer made a timely request for a formal hearing (DX 21). A hearing was scheduled before Administrative Law Judge Edward T. Miller on December 1, 1999, but on November 15, 1999, Judge Miller remanded the claim to the District Director to allow the development of medical evidence (DX 55). On January 26, 2001, the claim was again referred to the Office of Administrative Law Judge for a formal hearing (DX 78).

The Claimant filed an earlier claim on August 8, 1994, which was denied by the Director on January 12, 1995, on the grounds that the Claimant was not totally disabled by pneumoconiosis (DX 28-1, 28-10). The Claimant did not further pursue that claim. The Claimant also filed a claim with the Social Security Administration on February 28, 1970 (DX 27-1). Although the record is not clear, it appears that the claim was transferred to the Department of Labor, and after a number of interim determinations, the Claimant was awarded benefits as a working miner on September 8, 1982. On that same date, Robinson Phillips was notified that it was relieved of the responsibility for payment of Federal black lung benefits, actual or potential, in the claim (DX 27-32, 27-33). As the Claimant continued working, it does not appear that he ever received benefits pursuant to this determination.

ISSUES PRESENTED

The issues contested by the Employer are:

1. The timeliness of the claim.
2. The number of dependents.
3. The length of the Claimant's coal mine employment.
4. Whether the Claimant has pneumoconiosis.
5. If so, whether his pneumoconiosis arose out of his coal mine employment.
6. Whether the Claimant is totally disabled.
7. If so, whether the Claimant's total disability is due to pneumoconiosis.
8. Whether the Employer is the responsible operator.

(Tr. 14-15). The Director does not contest any issues.

APPLICABLE STANDARD

As the Claimant's January 1998 claim was filed more than one year after his earlier claim was finally denied, it is considered a duplicate claim and must be denied pursuant to 20 C.F.R. § 725.309 unless the Claimant can show that there has been a material change in conditions since the date of denial of the prior claim. If the Claimant is successful in showing such a change, then his claim must be evaluated under Part 718. *Dotson v. Director, OWCP*, 14 B.L.R. 1-10 (1990).

In *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995), the Third Circuit adopted the Sixth Circuit's standard for finding a "material change in conditions:" [also adopted by the Fourth Circuit in *Lisa Lee Mines v. Director, OWCP*, 57 F.3d 402 (1995) *aff'd.*, 86 F.3d 1348 (4th Cir. 1996)(*en banc*)]

> [T]o assess whether a material change is established, the ALJ must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Then the ALJ must consider whether all of the record evidence, including that submitted with the previous claims, supports a finding of entitlement to benefits.

Sharondale Corp. v. Ross, 42 F.3d 993, 997-998 (6th Cir. 1994).

Because this claim was filed after the enactment of the Part 718 regulations, the Claimant's entitlement to benefits will be evaluated under Part 718 standards. In order to establish entitlement to benefits under Part 718, the Claimant must prove that he has pneumoconiosis, that it arose out of his coal mine employment, and that the pneumoconiosis has caused him to be totally disabled.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted and arguments made.

Background

The Claimant was born on April 14, 1933 (DX 1). He married his wife, Athalene, on October 20, 1953; his wife lives with him and is dependent on him for support (DX 1, Tr. 16). I find that the Claimant has one dependent for purposes of augmentation of benefits under the Act, namely, his wife, Athalene Addair.

Timeliness of the Claimant's Claim

The Act, at 30 U.S.C. §§ 932(f), provides that "[a]ny claim for benefits by a miner under this section shall be filed within three years after whichever of the following occurs later": (1) a medical determination of total disability due to pneumoconiosis; or (2) March 1, 1978. The

Secretary of Labor's implementing regulations at 20 C.F.R. §§ 725.308 are more liberal to the claimant and read, in part, as follows:

> (a) A claim for benefits filed under this part by, or on behalf of, a miner shall be filed within three years after a medical determination of total disability due to pneumoconiosis which has been communicated to the miner or a person responsible for the care of the miner, or within three years after the date of enactment of the Black Lung Benefits Act of 1977, whichever is later. There is no time limit on the filing of a claim by the survivor of a miner.
>
> . . .
>
> (c) There shall be a rebuttable presumption that every claim for benefits is timely filed. However, except as provided in paragraph (b) of this section, the time limits in this section are mandatory and may not be waived or tolled except upon a showing of extraordinary circumstances.

Here, the Claimant testified that he was told by Dr. Baxter in 1979 that he had pneumoconiosis, and that he had a totally disabling pulmonary impairment due to his pneumoconiosis. He testified that Dr. Baxter also sent him a letter to this effect (Tr. 41-42). However, there is no such letter in the record, or a report from Dr. Baxter or any other physician indicating that the Claimant was diagnosed with totally disabling pneumoconiosis before January 1998. Thus, it is not possible to determine whether the Claimant's understanding that he had a totally disabling pulmonary impairment due to pneumoconiosis was based on an actual "medical determination." The Claimant cannot give himself a "medical determination," and the statute makes what he believes about his condition irrelevant to the initiation of the statute of limitations. *Peabody Coal Co. v. Director, OWCP*, 2002 WL 31205502, p. 4 (6th Cir. 2002). Moreover, even if there were a "medical determination" from Dr. Baxter in the record, it was legally rendered a misdiagnosis by virtue of the Director's November 1998 denial. *Id.*

Thus, I find that the Claimant's January 1998 claim for benefits was timely.[1]

Responsible Operator/*Length of Coal Mine Employment*

The Claimant claims that he has approximately thirty seven and a half years of coal mine employment, ending in 1988 (DX 1). The Director determined that the Claimant had established 37 years of coal mine employment; the Employer agrees that the Claimant has 19 years of coal mine employment (DX 78; Tr. 14). The Claimant's Social Security earnings records reflect that he worked as a coal miner from 1952 through 1988; from 1965 through 1984, he worked for Robinson-Phillips Coal Co., the named responsible operator, and from 1986 through 1988, he

[1] As I have dismissed Robinson Phillips as the responsible operator, *infra*, and the Director has not contested this issue, it is technically moot. I make these findings in the alternative, in the event that Robinson Phillips is ultimately determined to be the responsible operator.

worked for Black Horse Coal Mining (DX 3). I find that the Claimant has 36 years of coal mine employment.

The Social Security earnings records reflect that the Claimant last worked for Black Horse Coal Mining. The record indicates that Black Horse Coal Mining was insured by the West Virginia Coalworkers' Pneumoconiosis Fund until July 8, 1987, when it became unable to pay the premiums. It filed for Chapter 11 bankruptcy protection on January 19, 1989, which was converted to Chapter 7 bankruptcy status on April 25, 1990. Black Horse Coal Mining has not been formally dissolved, but the company is not in good standing because of non-payment of taxes. The record also shows that A. T. Massey, as lessor through Robinson Phillips Coal Co., began to pay employees and purchase equipment to keep the preparation plant operational through 1988 (DX 11). This is consistent with the Claimant's testimony: he stated that after a period of about 15 months, when he was off work due to a strike, he went back to work for Black Horse Coal at the same mine where he worked for Robinson-Phillips; the equipment was the same, as were most of the supervisors and employees (Tr. 22-24; 43-45).

In order to be deemed the responsible operator for this claim, the Employer must be the most recent employer in the coal mining industry for whom the Claimant worked for at least one year, including one day after December 31, 1969, and the most recent employer who has the financial ability to pay in the event benefits are awarded. 20 C.F.R. §§ 725.492(a), 493(a); *Coal v. East Kentucky Collieries*, 20 BLR 1-51 (1996); *Director, OWCP v. Trace Fork Coal Co. [Matney*], 67 F. 3d 503 (4th Cir. 1995), *rev'g in part sub nom., Matney v. Trace Fork Coal Co.*, 17 BLR 1-145 (1993). It is the duty of the Director, OWCP, to identify, notify, and develop evidence regarding potential responsible operators. *Director, OWCP, v. Trace Fork Coal Co.*, 67 F.3d 503 (4th Cir. 1995).

Black Horse Coal Mining is the last coal mine operator which employed the miner for a cumulative period of one year or more, and thus has primary liability for benefits on this claim. 20 C.F.R. § 725.492(a)(4). The record indicates that this company is uninsured, is no longer in good corporate standing, and has filed for bankruptcy protection. However, the record contains no evidence that Black Horse Coal Mining has in fact been adjudicated bankrupt (a fact that is easily documented), that it has been dissolved, or otherwise has no assets to assume liability for the Claimant's claim. Nor is there any evidence in the record to establish that its corporate officers are not financially able to pay benefits and should not be held personally liable for the payment of benefits.[2] See 20 C.F.R. 725.492(a); *Donovan v. McKee*, 845 F. 2d 70 (4th Cir. 1988).

As the record indicates that Black Horse Coal Mining was the most recent coal mining employer for whom the Claimant worked for a cumulative period of one year, and the Director has not established that this Employer is not capable of assuming liability for benefits, it is properly named as the responsible operator.

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Nor is there sufficient evidence in the record to establish Robinson Phillips' liability as a lessor to Black Horse Coal Mining. Although a reading of the Employer's Brief would suggest that there was no relationship between Black Horse Coal Mining and Robinson Phillips Coal Co., the record shows that Robinson Phillips Coal Co., which is a subsidiary of A. T. Massey, leased the coal mine in question to Black Horse Coal Mining. Where a lessor of a mine retains sufficient rights of control and supervision of mining operations, including right of inspection, right of ejectment and confession of judgment, and the right to direct the manner and extraction of coal, the lessor may be held to be the responsible operator. *Yebernetsky v. Elliot Coal Mining Co., Inc.*, BRB No. 84-2560 BLA (June 30, 1988)(unpublished), *aff'd on reconsideration* (1988)(unpublished).

In *Elliot Coal Mining Co. v. Director, OWCP*, 17 F.3d 616 (3d Cir. 1994), the court noted that the language of §§ 3(d) of the Act requires that an owner or lessor retain "some right to control or supervise others' mining operations on land they own or lease." In this vein, the Third Circuit interpreted this regulatory provision to require "actual operation, supervision or control and that the mere existence of an unexercised right to control cannot make a lessor or owner a responsible operator." Rather, the lessor or owner must have "substantial, effective control" over the mining operation.

Here, although the record reflects that in 1988 Massey, through Robinson Phillips, had been paying the payroll and union benefits, and purchasing equipment necessary to keep the preparation plant operational, there is no evidence that Massey or Robinson Phillips had substantial and effective control over the actual mining operations. The letter from Lewis C. Thomas, President of Black Horse Coal Mining, to the West Virginia Coal Workers Pneumoconiosis Fund, dated November 21, 1988, states that although Massey had forced them to close all mining operations since mid-October, they had been told to continue managing the Robinson Phillips preparation plant so that Massey could meet their 1988 obligations. There is simply not enough evidence in the record to support a finding that Robinson Phillips had substantial and effective control over that mining operation.

Accordingly, Robinson Phillips is hereby dismissed as a named responsible operator.

The Medical Evidence

The following new medical evidence is in the record.[3]

X-Ray Evidence[4]

[3] In determining whether the Claimant has established a change in conditions since the January 12, 1994 denial by the Director, I have not considered interpretations of x-rays that predate that determination, as they are not material to the issue of change in conditions.

[4] B - B Reader; and BCR - Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A "B Reader" has demonstrated

Exhibit No.	***Date of X-Ray***	***Reading Date***	***Physician/ Qualifications***	***Impression***
DX 33	2-3-98	4-26-99	Hippensteel/B	2/3, q, q
DX 32	2-3-98	4-6-99	Dahhan/B	2/2, q, q
DX 26	2-3-98	12-31-98	Kim/B, BCR	0/1, q, t
DX 25	2-3-98	12-10-98	Wheeler/B, BCR	0/1, q, q
DX 19	2-3-98	10-13-98	Castle/B	2/2, q, r
DX 25	2-3-98	12-8-98	Scott/B, BCR	0/1, t, q
DX 10	2-3-98	2-2-98	Forehand/B	2/1, q, q, Category A opacities
DX 9	2-3-98	2-22-98	Cole/B, BCR	2/1, q, r, Category A opacities
DX 36	11-4-98	6-29-98	Kim/B, BCR	0/1, q, q
DX 35	11-4-98	6-18-99	Wheeler/B, BCR	0/1, q, q
DX 35	11-4-98	6-18-99	Scott/B, BCR	1/1, q, q
DX 34	11-4-98	2-17-99	Castle/B	2/1, q, q
DX 54	11-4-98	11-10-99	Hippensteel/B	2/1, r, q
DX 46	11-4-98	10-22-99	Dahhan/B	½, q, q
DX 77	7-3-99	1-8-01	Wheeler/B, BCR	Negative for pneumoconiosis
DX 77	7-3-99	1-8-01	Scott/B, BCR	1/1, s, q
EX 1	7-3-99	1-17-01	Kim/B, BCR	1/0, t, q
EX 3	7-3-99	2-9-01	Castle/B	2/2, q, r
EX 3	7-3-99	2-22-01	Hippensteel/B	2/2, q, r
DX 44	7-3-99	7-5-99	Deponte/B, BCR	2/2, q, p, Category B opacities
DX 77	11-5-99	1-8-01	Wheeler/B, BCR	Negative for pneumoconiosis
DX 77	11-5-99	1-8-01	Scott/B, BCR	1/0, s, q

proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and an examination, as proficient in interpreting x-ray films of all kinds including images of the lungs.

DX 61	11-5-99	11-5-99	Robinette/B	2/1, r, q, Category A opacity
DX 61	11-5-99	11-5-99	Mullens	Nodular interstitial lung disease with right upper lobe mass consistent with silicosis/CWP and progressive massive fibrosis
EX 1	11-5-99	1-17-01	Kim/B, BCR	1/0, s, q
EX 3	11-5-99	2-9-01	Castle/B	2/2, q, r
EX 3	11-5-99	2-22-01	Hippensteel/B	2/2, q, r
DX 75	8-21-00	11-28-00	Wheeler/B, BCR	0/1, q, q
DX 75	8-21-00	11-22-00	Scott/B, BCR	0/1, q, q
EX 1	8-21-00	1-26-01	Castle/B	2/2, q, r
EX 2	8-21-00	2-5-01	Dahhan/B	½, q, q
EX 4	8-21-00	12-14-00	Kim/B, BCR	0/1, q, q
EX 8	7-13-01	12-5-01	Wheeler/B, BCR	1/0, q, q
EX 8	7-13-01	12-5-01	Scott/B, BCR	1/1, t, q
EX 8	7-13-01	12-11-01	Kim/B, BCR	1/0, q, t
EX 9	7-13-01	12-18-01	Castle/B	2/1, q, r
EX 10	7-13-01	12-24-01	Dahhan/B	2/2, q, q
EX 15	7-13-01	1-7-02	Hippensteel/B	2/2, q, q
CX 2	7-17-01	7-17-01	Patel/B, BCR	2/2, q, t, Category B opacities
EX 12	11-30-01	2-28-02	Wheeler/B, BCR	0/1, q, q
EX 12	11-30-01	2-26-02	Scott/B, BCR	1/1, q, t
EX 12	11-30-01	2-26-02	Scatarige/B, BCR	1/0, q, q
EX 13	11-30-01	3-12-02	Castle/B	2/1, q, q
EX 14	11-30-01	3-18-02	Dahhan/B	½, q, r
EX 15	11-30-01	4-11-02	Hippensteel/B	2/1, q, q
EX 16	11-30-01	4-29-02	Navani/B, BCR	1/1, q, r
EX 20	11-30-01	5-17-02	Repsher/B	1/1, q, q

CX 6	11-30-01	12-3-01	Deponte/B, BCR	2/2, q, r, Category B opacities

Pulmonary Function Studies

Exhibit No.	***Date***	***Age/Ht***	***FEV1***	***FVC***	***MVV***	***Effort***
DX 6	2-3-98	64/71"	3.00	3.99	90	Good
DX 34	11-4-98	65/71"	3.04 3.13*	4.05 4.02*	86 90*	Fair
DX 61	11-5-99	66/71"	2.71	3.78		Good
DX 74	8-21-00	67/71"	2.43	3.47	45[5]	Claimant refused to take bronchodilators
CX 4	7-17-01	68/71"	3.02 2.79*	4.26 3.74*	115 117*	

Arterial Blood Gas Studies

Exhibit No.	***Date***	***Physician***	***pCO2***	***pO2***	***At rest/exercise***
DX 8	2-3-98	Forehand	37/35	67/84	At rest/after exercise
DX 34	11-4-98	Castle	41.3	75	At rest
DX 61	11-5-99	Robinette	38.1	83	At rest
DX 74	8-21-00	Hippensteel	37.7	77.6	At rest
CX 3	7-17-01	Rasmussen	37/32	72/83	At rest/after exercise

Medical Opinion Evidence

Dr. Kirk E. Hippensteel

Dr. Hippensteel examined the Claimant on November 9, 2000, at the request of the

[5] Dr. Hippensteel noted that the MVV was severely reduced, with suboptimal tidal volumes, making it invalid.

Employer (DX 74). He noted the Claimant's 37.5 year history of underground coal mine employment, ending in 1988. The Claimant reported that Dr. Baxter first told him in 1978 or 1979 that he had black lung disease; he had no history of pneumonia, asthma, or tuberculosis, fungal infections, or exposure to chickens. The Claimant smoked less than a half pack of cigarettes a day from age 17 until the 1960s.

On examination of the Claimant, Dr. Hippensteel noted that his lungs were clear bilaterally, with no rales or wheezes; he had good air movement bilaterally, with normal chest configuration. The Claimant's x-ray showed increased interstitial markings classified as 2/2, q, q, in all lung zones, and axillary coalescence, but no large opacities. There were partially calcified hazy infiltrates in both apices that were not suggestive of pneumoconiosis, but looked like granulomatous disease. According to Dr. Hippensteel, it took eight efforts to get correlation within 5% on the spirometry testing. The Claimant's FEV1/FVC ration was normal, and showed no obstruction. The Claimant refused to use any bronchodilators. His MVV was severely reduced, but invalid due to the very small suboptimal tidal volumes. The Claimant's total lung capacity was normal, with no restriction. His diffusion was normal, as was his oxygenation.

Dr. Hippensteel concluded that the Claimant has simple pneumoconiosis, but not complicated pneumoconiosis, or any ventilatory or gas exchange impairment related to pneumoconiosis. He felt that the Claimant had chest x-ray findings consistent with granulomatous disease of undetermined etiology. In Dr. Hippensteel's opinion, the Claimant had no pulmonary impairment that would prevent him from returning to his previous coal mining work.

Dr. Hippensteel also reviewed the Claimant's medical records, and determined that his conclusions were still valid. Noting that Dr. Wheeler felt that the Claimant's x-rays were consistent with granulomatous disease, he stated that the Claimant's chest x-ray pattern does not exclude pneumoconiosis as a factor in these abnormalities. He agreed that the Claimant does not have complicated coal workers' pneumoconiosis radiographically, and does not have pulmonary function study abnormalities to correlate with the development of complicated pneumoconiosis. Dr. Hippensteel stated that the Claimant had evidence of normal pulmonary function long after he had left his work in the mines, and "without progression of abnormalities on his chest x-ray that suggest progression of impairment referable to any lung disease."

Dr. Hippensteel noted that a negative tuberculosis skin test does not rule out granulomatous disease in the lungs, and partially calcified nodules not of an eggshell type suggesting silicosis are compatible with granulomatous inflammation rather than coal workers' pneumoconiosis. He did agree with Dr. Stewart, however, that some of the abnormalities were also compatible with simple pneumoconiosis. However, he felt that the findings were not compatible with complicated pneumoconiosis, because the findings on x-ray do not suggest a coalescence of small opacities into a large opacity. According to Dr. Hippensteel, "this finding is corroborated by lack of supporting pulmonary function evidence to suggest that such an intensive inflammatory reaction as occurs with progressive massive fibrosis is present in this case." He noted that the objective pulmonary function data showed that the Claimant had no pulmonary impairment, and could return to his previous job in the mines.

Dr. Hippensteel reviewed additional medical records, and provided a report dated May 21, 2002 (EX 19). Noting that there were dissenting views on the issue of complicated pneumoconiosis, he felt that his previous conclusions were valid, and corroborated by other experts. He felt that the radiographic findings were not suggestive of complicated pneumoconiosis or progressive massive fibrosis, as corroborated by the fact that the Claimant had no pulmonary impairment, which would be expected if he had complicated pneumoconiosis or progressive massive fibrosis.

Dr. Hippensteel testified by deposition on June 17, 2002 (EX 23). He noted that on his x-ray of the Claimant, he found axillary coalescence but no large opacities; he defined coalescence as areas of close proximity of nodules, in which specific nodules are still visible, as opposed to conglomeration or development of a large opacity. He again stated that although the Claimant had findings compatible with simple pneumoconiosis, he did not have findings of complicated pneumoconiosis, based on his x-rays, but also on the fact that his pulmonary function is normal. According to Dr. Hippensteel, some abnormalities of function would be expected with complicated disease; as the Claimant has none, that is corroborative evidence of the lack of complicated pneumoconiosis.

Dr. Hippensteel testified that the two areas of coalescence in the right upper lobe had a combined diameter of about 5 X 5 centimeters, and there was a 2 centimeter diameter area in the left apex.

Dr. Emory Robinette

Dr. Robinette examined the Claimant on December 1, 1999 (DX 61). He noted that the Claimant worked for about 32 years as an underground coal miner; in the 1970s, he was told that he had black lung disease, and spent the next 5 years driving a truck. Dr. Robinette noted that the Claimant smoked about a half pack of cigarettes a day for 30 years. On examination of the Claimant, Dr. Robinette found diminished breath sounds without significant wheezes, and a few inspiratory crackles in the mid lung zones bilaterally. The Claimant's x-ray showed evidence of diffuse interstitial pulmonary fibrosis, with evidence of a large fibrotic opacity, about 3/4 cm., in the right upper lobe. There was evidence of distortion of the hilum, axillary coalescence, and nonspecific pleural thickening, which he felt was consistent with complicated pneumoconiosis, with a profusion abnormality of 2/1, r, q, with a category A mass in the right upper lobe, and axillary coalescence in the left upper lobe.

The Claimant's pulmonary function studies showed normal spirometry, with evidence of mild restrictive lung disease. The diffusion capacity was normal, as were the arterial blood gas study results at rest. Dr. Robinette concluded that the Claimant had complicated pneumoconiosis, with underlying progressive massive fibrosis, and restrictive lung disease.

Dr. Robinette examined the Claimant again on July 17, 2001 (CX 1). He noted the Claimant's coal mine work history, as well as his previous smoking habit. His family history was negative for tuberculosis. On examination of the Claimant, Dr. Robinette found that his chest

expansion and diaphragmatic excursions were normal, and breath sounds were moderately reduced. There were no rales, rhonchi, or wheezes. He noted that an x-ray interpreted by Dr. Patel showed pneumoconiosis 2/2, q, t, in all lung zones, with coalescence of small opacities in the upper lung zones, and poorly detailed non calcified, ill defined Category B large opacities in the upper lung zones. The ventilatory function studies were normal, without significant change following use of bronchodilators. The Claimant's maximum breathing capacity was within normal limits; the single breath carbon monoxide diffusing capacity was moderately reduced. The results of the resting blood gas studies were normal. After exercise, the Claimant's volume of ventilation was markedly increased, but he retained a breathing reserve of 65 liters; there was minimal increase in VD/VT ration. The Claimant's oxygen transfer was normal, and he was not hypoxic.

Dr. Robinette felt that the studies indicated poor exercise tolerance, but no significant loss of lung function, and that the Claimant retained the pulmonary capacity to perform his previous coal mining job. He noted that the Claimant had a significant history of exposure to coal mine dust, and extensive x-ray abnormalities consistent with complicated pneumoconiosis, Category B, as a consequence of his coal mine employment.

Dr. Robinette testified by deposition on July 24, 2001 (EX 7). He indicated that the Claimant's pulmonary function study results, which raised concern that he might have a restrictive impairment, did not preclude him from returning to work as an underground coal miner. However, by technical definition, the x-ray showed an impairment or disability for working as a coal miner, because he could not be exposed to any dust, which would cause a significant probability of progression of the radiographic abnormalities.

According to Dr. Robinette, there was no evidence that the Claimant had tuberculosis. The Claimant denied any exposure, and there was no family history of tuberculosis. He also felt that the radiographic pattern was not really consistent with tuberculosis. Dr. Robinette noted that he is a tuberculosis control physician for the State of Virginia, and sees quite a bit of tuberculosis in southwest Virginia. He did not think the Claimant's x-ray was consistent with tuberculosis as a primary differential. According to Dr. Robinette, a tuberculosis skin test would indicate whether the Claimant had a past or recent infection with tuberculosis of any significance.

Dr. Robinette indicated that in his personal experience in the practice of treating pulmonary disease, persons have progressed from simple pneumoconiosis to progressive massive fibrosis without continued dust exposure.

Dr. A. Dahhan

Dr. Dahhan reviewed the Claimant's medical records at the request of the Employer, and provided a report dated July 14, 1999 (DX 40). Based on that review, he concluded that the Claimant has category II simple coal workers' pneumoconiosis, but no evidence of complicated pneumoconiosis or progressive massive fibrosis, as demonstrated by the normal clinical examination of his chest, with no crackles or crepitation, and negative x-ray readings for complicated pneumoconiosis by the majority of the readers. He also noted that the Claimant had

normal respiratory mechanics and diffusion capacity, and adequate blood gas exchange mechanisms at rest and after exercise. According to Dr. Dahhan, the Claimant had no evidence of a respiratory impairment or disability as a result of his pneumoconiosis. He did have a history consistent with bronchitis, which Dr. Dahhan felt resulted from his lengthy smoking history, but did not cause pulmonary disability. He felt that the Claimant could return to his previous mining work from a respiratory standpoint.

Dr. Dahhan reviewed additional medical records, and prepared a report dated October 25, 1999 (DX 46). He again concluded that the Claimant had radiological findings suggestive of simple pneumoconiosis, although Dr. Wheeler, an expert in the field of radiologically identifying pneumoconiosis, felt that the abnormalities were due to tuberculosis. He felt that there was no evidence of complicated pneumoconiosis or progressive massive fibrosis, based on the x-ray interpretations, as well as the clinical examinations of the chest, pulmonary function studies, and arterial blood gases. The Claimant had no evidence of pulmonary disability, and retained the respiratory capacity to return to his previous coal mining work.

Dr. Dahhan reviewed additional records, and prepared a report dated July 5, 2001 (EX 5). Again, he concluded that the Claimant had radiological findings consistent with simple pneumoconiosis, but no evidence of complicated pneumoconiosis or progressive massive fibrosis. He noted that the Claimant's clinical examination showed no abnormalities consistent with complicated pneumoconiosis, and his x-ray had been read as negative for large opacities or complicated pneumoconiosis by the majority of readers.[6] The Claimant's spirometry, lung volumes, and diffusion capacities were normal, arguing against any abnormality in his respiratory reserve that could have resulted from complicated pneumoconiosis, if it was present. He felt that the Claimant had no objective findings to indicate any functional respiratory impairment, and retained the capacity to continue his previous coal mining job.

Dr. Dahhan also reviewed additional records, and provided a report dated May 2, 2002 (EX 17). Based on that review, he again concluded that the Claimant had radiological findings sufficient to justify a diagnosis of simple pneumoconiosis, but no objective findings to indicate the presence of complicated pneumoconiosis or progressive massive fibrosis. He noted that the x-ray failed to show such an abnormality, especially when reviewed by experts in the radiological field of pneumoconiosis, in particular the physicians from Johns Hopkins. He noted that the Claimant's chest CT scan was read by the same group as negative for complicated pneumoconiosis, and the Claimant's clinical chest examination showed no findings to support a diagnosis of progressive massive fibrosis. Finally, the Claimant's pulmonary function studies did not support a diagnosis of the restrictive ventilatory defect that is usually seen in complicated pneumoconiosis.

Dr. Dahhan repeated that from a functional respiratory standpoint, the Claimant had no

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[6] Dr. Dahhan's report states: "Also, his CT of the chest was interpreted by many experts in the radiological field of complicated coal workers' pneumoconiosis." The record does not indicate that the Claimant underwent any CT scans.

evidence of total or permanent pulmonary disability, and retains the respiratory capacity to return to his previous coal mining work.

Dr. Thomas M. Jarboe

Dr. Jarboe reviewed the Claimant's medical records at the request of the Employer, and provided a report dated July 20, 1999 (DX 39). After his review, Dr. Jarboe concluded that there was sufficient objective radiographic evidence to justify a diagnosis of simple coal workers' pneumoconiosis. However, noting that nearly every reader interpreted the pneumoconiosis as simple, not complicated, he concluded that the Claimant did not have complicated pneumoconiosis. In addition, he did not feel that the Claimant had any significant respiratory impairment, based on his most recent examinations by Dr. Forehand and Dr. Castle, who both recorded normal spirometry, and essentially normal gas exchange on exercise. He noted that Dr. Castle also recorded normal total lung capacity and diffusion capacity, and concluded that the Claimant had no respiratory impairment or disability. He noted that Dr. Forehand concluded that the Claimant had significant lung injury, based on the presence of pneumoconiosis on the x-ray, but not on pulmonary function testing. Dr. Jarboe concluded that the Claimant had no respiratory impairment or disability, and retained the respiratory capacity to do his previous coal mining work.

Dr. Jarboe reviewed additional medical records, and provided a report dated November 1, 1999 (DX 50). He felt that there was sufficient objective evidence to justify a diagnosis of simple pneumoconiosis. Noting that there was contention as to whether the Claimant has complicated pneumoconiosis, Dr. Jarboe stated that he did not feel that there was adequate evidence of complicated pneumoconiosis. He noted that Dr. Dahhan described coalescence of nodules on the November 12, 1991 x-ray, a finding which could be confused with complicated pneumoconiosis. He continued to believe that there was no evidence of any pulmonary impairment, and that the Claimant retained the respiratory capacity to return to his previous coal mining work.

Dr. Jarboe reviewed additional medical records, and provided a report dated July 13, 2001 (EX 5). He continued to feel that there was sufficient objective evidence to justify a diagnosis of simple pneumoconiosis. Dr. Jarboe stated:

> There continues to be contention as to whether or not he had complicated pneumoconiosis. Dr. Robinette read the film of 11/05/99 as showing Category 2/1 A. On the other hand, many other highly qualified B readers have not felt that complicated pneumoconiosis was present. It is of interest that Dr. Wheeler read several films as showing an infiltrate or mass in the right upper lobe. However, his colleagues, namely Drs. Kim and Scott specifically described this area as an infiltrate. This would imply that the area in the right upper lobe is not a true mass. Furthermore, the description of this area as an infiltrate is consonant with the readings of a number of other B readers who felt that the changes represent coalescence of nodules and not a solid mass. Thus I am led to conclude within a reasonable degree of medical certainty that Mr. Addair has simple coal workers' pneumoconiosis. I do not feel that the evidence supports a diagnosis of complicated pneumoconiosis.

Dr. Jarboe also continued to feel that the Claimant does not have significant respiratory impairment, and that he fully retains the respiratory capacity to perform his previous coal mining work.

Dr. Jarboe reviewed additional medical records, and provided a report dated May 17, 2002 (EX 18). Again, he felt that there was sufficient objective evidence to justify a diagnosis of pneumoconiosis. He noted that the evidence on complicated pneumoconiosis was conflicting, and he did not feel that he could say within a reasonable degree of medical certainty that the Claimant had complicated pneumoconiosis. He again concluded that the Claimant had no significant pulmonary or respiratory impairment, and that he would be able to perform his previous coal mining job.

Dr. Samuel V. Spagnolo

Dr. Spagnolo reviewed the Claimant's medical records at the request of the Employer, and provided a report dated July 12, 1999 (DX 37). Based on his review, he concluded that the Claimant does not have pneumoconiosis, nor does he have a pulmonary or respiratory impairment attributable to pneumoconiosis. Dr. Spagnolo noted the Claimant's history of coal mine employment, as well as his smoking history. In his opinion, there was sufficient information for his conclusion that the Claimant does not have pneumoconiosis, which was based on the multiple physical examinations for evidence of interstitial lung disease, the lack of any abnormal lung sounds, the pattern of chest x-ray findings, and the normal test results for lung function. He placed greatest weight on the x-ray reports of Dr. Wheeler, Dr. Scott, and Dr. Kim, whose reports were uniformly consistent, and did not indicate the presence of pneumoconiosis. He also noted that the most recent test results showed normal total lung capacity, forced vital capacity, FEV1/FVC, and lung diffusion. In addition, the blood gas values were normal at rest and during exercise. There was no evidence of an obstructive or restrictive lung impairment, no gas exchange defect, and no basis for a diagnosis of interstitial lung disease. In his opinion, the Claimant is not disabled by a respiratory condition related to pneumoconiosis, and would be able to return to his previous coal mining work. This opinion would not change even if the Claimant were subsequently found to have pneumoconiosis.

Dr. Spagnolo reviewed additional medical records and provided a report dated November 3, 1999 (DX 51). His conclusions remained unchanged; specifically, he felt that the Claimant does not have pneumoconiosis, or a pulmonary or respiratory impairment attributable to pneumoconiosis.

Dr. Spagnolo reviewed additional medical records, and prepared a report dated July 10, 2001 (EX 5). In reviewing Dr. Robinette's December 1, 1999 report, he disagreed with his finding of a mild restrictive defect on the basis of the total lung capacity value, noting that it was within normal limits according to the American Thoracic Society Guidelines. He felt that the tests did not demonstrate an obstructive or restrictive lung defect or impairment.

Noting Dr. Wheeler's extensive qualifications and experience, and his stature as a pre-

eminent radiologist, he placed the greatest weight on his x-ray interpretations, noting that the additional x-rays reviewed by Dr. Wheeler since his deposition continued to support his earlier interpretations.

Dr. Spagnolo's conclusions were unchanged: he felt the evidence was sufficient to conclude that the Claimant does not have a chronic restrictive or pulmonary impairment arising out of his coal mine employment. In his opinion, the Claimant does not have simple or complicated pneumoconiosis, and none of his symptoms, complaints, or medical conditions is related to his coal dust exposure or coal mine employment.

Dr. Spagnolo reviewed additional medical records, and provided a report dated May 19, 2002 (EX 21). He again concluded that the Claimant is not totally and permanently disabled from a respiratory condition, and that he could return to his regular coal mining work. Again, he relied heavily on the radiographic interpretations by Dr. Wheeler. Dr. Spagnolo concluded that sarcoidosis was the diagnosis that would best explain the Claimant's total clinical picture. According to Dr. Spagnolo, this diagnosis explains the Claimant's relatively stable clinical course since 1979, the normal lung function test results, and the pattern of findings on the chest x-rays. He did not feel that the Claimant had a chronic restrictive or obstructive pulmonary impairment arising out of his coal mine work. Nor did he feel that the Claimant had complicated pneumoconiosis.

Dr. James R. Castle

Dr. Castle examined the Claimant at the request of the Employer on June 9, 1999 (DX 34). He noted the Claimant's history of coal mine employment, as well as his cigarette smoking history. On examination of the Claimant, Dr. Castle noted a normal AP chest diameter. The Claimant had no use of accessory muscles with quiet breathing, and no intercostal retractions. He had normal fremitus and normal percussion note, and normal and equal breath sounds throughout. He had no rales, rhonchi, wheezes, rubs, crackles, or crepitations. The x-ray film, dated November 4, 1998, showed q/q type opacities in all zones, with profusion of 2/1. There were no large opacities, but there was evidence of axillary coalescence in the right upper lung zone. According to Dr. Castle, these findings are consistent with simple coal workers' pneumoconiosis. Dr. Castle noted similar findings on x-rays dated in 1980, 1982, and 1991.

Dr. Castle also obtained pulmonary function studies, which were valid. The spirometry results were normal, with no evidence of obstruction. Lung volumes were normal, with no evidence of restriction; diffusion was normal. Finally, the resting arterial blood gas results were normal. Dr. Castle concluded that there was radiographic evidence of simple pneumoconiosis, but no respiratory impairment from any cause.

Dr. Castle also reviewed additional medical records, concluding that the Claimant has radiographic evidence of simple pneumoconiosis. However, according to Dr. Castle, the Claimant did not demonstrate consistent physical findings indicating the presence of an interstitial pulmonary process as would be expected with clinically significant pneumoconiosis. Dr. Castle stated:

> It was also my opinion that the area of axillary coalescence noted in 1991 was consistent with an area of axillary coalescence noted on the 1998 film. It was my opinion that this did not represent a large opacity because individual nodularity could easily be distinguished, and this, in my opinion, constitutes axillary coalescence rather than progressive massive fibrosis.

Dr. Castle felt that the period of time over which the coalescence developed, as well as its location, mitigated against a malignant process. He concluded that the Claimant has radiographic evidence of simple pneumoconiosis, but that he does not have complicated pneumoconiosis. He suffers from no pulmonary impairment or disability arising from his coal mining employment, and retains the respiratory capacity to return to his previous coal mining job.

Dr. Castle reviewed additional medical records, and prepared a report dated November 1, 1999 (DX 47). He concluded that the Claimant had radiographic evidence of simple pneumoconiosis. He noted that the additional medical data conformed to his previous opinions, with the exception of Dr. Wheeler's testimony. Noting that it was difficult to ignore or refute Dr. Wheeler's opinion because of his authority and expertise in this area, he conceded that it was possible that Dr. Wheeler was correct that all of the changes were due to old granulomatous disease. Dr. Castle felt that there was evidence of old granulomatous disease on the x-rays, but that they also showed evidence of simple pneumoconiosis. He did not believe that there was evidence of complicated disease, and agreed with Dr. Wheeler on this issue.

Dr. Castle continued to believe that the Claimant did not have any respiratory impairment, and could return to his previous coal mining job.

Dr. Castle reviewed additional medical records, and prepared a report dated July 10, 2001 (EX 5). Based on this review, he continued to believe that the Claimant has radiographic evidence of simple pneumoconiosis, but no evidence of complicated pneumoconiosis or progressive massive fibrosis. He noted that the Claimant did not show consistent findings of rales, crackles, or crepitations, and the valid physiologic studies have been entirely normal. He disagreed with Dr. Robinette's conclusion that the Claimant had possible restrictive disease as manifested by a reduction in total lung capacity: he stated that this statement was incorrect, because the total lung capacity as observed by Dr. Robinette was entirely within normal limits at 84% of predicted. This was confirmed by Dr. Hippensteel's study, which showed 85% of the predicted value. According to Dr. Castle, the Claimant has no evidence of respiratory impairment from any cause. His arterial blood gas studies have been normal, and have shown no abnormality of blood gas mechanisms.

In Dr. Castle's opinion, although the Claimant has radiographic evidence of simple pneumoconiosis, he does not evidence of complicated pneumoconiosis, either by radiographic evaluation, or physiologic testing.

Dr. Castle testified by deposition on January 14, 2002, after reviewing additional medical records (EX 11). Dr. Castle referred to the November 5, 1999 x-ray, stating that he found evidence of q and r opacities in all lung zones, with a profusion of 2/2. He found no large

opacities, but there was evidence of axillary coalescence. According to Dr. Castle, axillary coalescence is the coming together of nodules that are still distinct in quality; they form a rosette, or a rounded type of abnormality. He described it as a coming together of nodules that are still individual and have not formed a large opacity. Again, on the August 21, 2000 x-ray, he noted axillary coalescence, but no large opacities. On the July 13, 2001 x-ray, he found q and r type opacities in all lung zones, with a profusion of 2/1, and axillary coalescence, but no large opacities.

According to Dr. Castle, there is generally a tendency in the literature that when pneumoconiosis progresses to complicated, respiratory impairment increases, and with a Category B or C, one would generally expect to see respiratory impairment. If the Claimant had a Category B opacity, it would be very, very likely that he would have some degree of functional abnormality, as a Category B lesion would be expected to, and usually does, cause a significant degree of both obstructive and restrictive impairment.. He felt that the fact that there was none was evidence arguing against the presence of a Category B lesion.

Dr. J. Randolph Forehand

Dr. Forehand examined the Claimant on February 3, 1998 (DX 7). He noted the Claimant's history of coal mine employment, as well as his smoking history. On examination of the Claimant, he found breath sounds of normal quality and distribution, and no dullness to percussion. The Claimant's x-ray of the same date showed complicated pneumoconiosis. His pulmonary function studies showed a normal ventilatory pattern, and the arterial blood gas study results showed no hypoxemia at rest or with exercise, and no metabolic disturbance.

Dr. Forehand's diagnosis was complicated pneumoconiosis, on the basis of the Claimant's x-ray and 37 year history of coal mine employment. According to Dr. Forehand, significant lung injury had occurred, and further exposure to coal dust or silica should be avoided. He stated that the Claimant was totally and permanently impaired, with his pneumoconiosis the sole factor contributing to his disability.

Dr. Forehand testified by deposition on July 27, 2001 (EX 6). He noted that he read the Claimant's chest x-ray dated February 3, 1998 as showing rounded opacities with a profusion of 2/1, and a large opacity, category A, in the right upper zone. He also recommended that a follow up x-ray be obtained in six to eight weeks to rule out cancer or tuberculosis. According to Dr. Forehand, his finding that the Claimant was totally and permanently disabled was based on his findings of complicated pneumoconiosis by x-ray.

Dr. Forehand stated that if the x-ray findings represented cancer, it would have progressed within a matter of weeks, and the chances were that the Claimant would not be alive. With respect to tuberculosis, he was not able to rule it out, although he felt that the most likely etiology was pneumoconiosis. He noted that there was an overlap in appearance, and that coal miners are more susceptible to tuberculosis, and thus it was important to rule it out. According to Dr. Forehand, pneumoconiosis and tuberculosis can co-exist, and one does not exclude the other. He stated that

a diagnosis of tuberculosis is made clinically, not on the basis of x-rays or CT scans. According to Dr. Forehand, pneumoconiosis can result in an asymmetrical disease process, and can occur exclusively on one side. Nor would the fact that the disease process was in the left apex, and did not involve the middle lung zones, exclude pneumoconiosis.

Dr. Paul S. Wheeler

Dr. Wheeler testified by deposition on August 2, 1999 (DX 41). Dr. Wheeler had been asked to review a series of six of the Claimant's x-ray films. The first, dated March 17, 1980, was barely readable, because it was underexposed. Nevertheless, Dr. Wheeler found 0/1 nodules, q, q, in the right upper zone, and possibly in the midline zones. He stated that a few of the small nodules could be pneumoconiosis, but the asymmetry, and uncertainty about the midline zone favored tuberculosis, which typically involves one upper lung zone, or gives an asymmetrical pattern or peripheral involvement. Since the Claimant's nodules were mainly in the periphery, or the right upper lobe, it was tuberculosis until proven otherwise.

Dr. Wheeler reviewed two x-rays dated January 18, 1982, which was also underexposed. However, he found profusion of 0/1, qu, q, definitely in the right upper lobe, but questionable in the mid lung zones. As it was an asymmetrical pattern, he felt that it strongly favored tuberculosis.

The next x-ray that Dr. Wheeler reviewed was dated November 12, 1991, and was also underexposed. There were definite nodules in the right upper lobe, and a possible two centimeter mass or pleural fibrosis in the lateral portion of the right upper lobe. There were also small nodules and tiny calcified granulomata in the lateral periphery of the right upper lobe and mid lung, and a few tiny calcified granulomata in the lower apices and lateral periphery of the left upper lobe. According to Dr. Wheeler, calcified granulomata, particularly when they are in the upper lobes, are tuberculosis until proven otherwise. There was also a one to two centimeter mass, which he did not classify as a large opacity because it was in the periphery. In his experience, silicosis and pneumoconiosis result in small rounded nodules in the central portion of the mid and upper lung zones. Thus, when large opacities occur, they result from the merging of these nodules. Since the nodules are central, most of the large opacities he has seen have been bilateral. He felt that a peripheral lesion, or a mass in the periphery or one apex is much more likely to be tuberculosis or cancer, or some other disease.

The next film that Dr. Wheeler reviewed was dated February 3, 1998, and it was also underexposed. Dr. Wheeler felt that there were definite nodules in the upper and mid lung zones, at 0/1 profusion, and a three centimeter mass or fibrosis in the lateral portion of the right upper lobe. Additionally, there was a one to one and a half centimeter mass or fibrosis in the medical left apex that was compatible with conglomerate tuberculosis, more likely than histoplasmosis or cancer. He noted that the mass in the right upper lobe was seen nearly seven years earlier, and if it were cancer would have progressed, and possibly been fatal. He also noted that a lot of the x-ray changes took place in the last decade, and in his experience, silicosis stabilizes at the point of no more exposure.

Finally, Dr. Wheeler reviewed a film dated November 4, 1998, which was also underexposed. Again, he felt that it showed conglomerate tuberculosis, with some nodules and scars in the upper lobes, and in the apices. He stated:

> I've seen cases of silicosis involve the apices and the lung periphery, but when they do they predominate massively in the central portions and they basically spill over into the apices, and sometimes into the lower lungs. In this case there is some right lower lung involvement. But typically, at least since World War II, the cases of silicosis have been primarily the upper lobes or upper and mid lung zones, not the lower lobes.

According to Dr. Wheeler, of the two diseases that cause nodules and scarring in the lungs, tuberculosis is by far the most likely to cause upper lobe disease, and apical disease is its "prime territory." Dr. Wheeler again stated that in his opinion, the Claimant had tuberculosis until proven otherwise. Although he conceded that some of the nodules could be silicosis, he felt that it was a minimal component of the disease. He stated that tuberculosis was by far the most likely to give the particular pattern and changes as shown in the Claimant's x-rays. He noted that, in his experience, the patterns of silicosis and pneumoconiosis stabilize once exposure is stopped; if a mass develops, one should be worried about cancer, or active tuberculosis or other infection. He also felt that the mass was conglomerate tuberculosis until proven otherwise.

Dr. Wheeler reviewed a series of eight chest x-rays taken between March 17, 1980 and August 21, 2000, and provided a report dated July 5, 2001 (EX 5). On all of these films, he found subtle nodules, mainly in the lateral periphery of the right upper lung, compatible with granulomatous disease, specifically tuberculosis, which preferentially attacks the upper lobes. Dr. Wheeler noted that the November 12, 1991 x-ray showed a possible 1-2 cm. mass or pleural fibrosis in the lateral portion of the right upper lobe, which he felt was compatible with granulomatous disease, or possibly a tumor. On subsequent films, there was a mass of variable size, up to 5 X 4 cm. in the lower lateral portion of the right upper lobe, which he felt was most likely conglomerate granulomatous disease. He noted that the Claimant's disease was largely peripheral and asymmetrical, favoring granulomatous disease over pneumoconiosis, which results in symmetrical nodules in the central portion of the mid and upper lungs.

Dr. Wheeler noted that on the earlier films he considered the possibility that some of the small nodules were pneumoconiosis, profusion of 0/1, but the pattern evolved into a mass like appearance on later films, leading him to conclude that granulomatous disease was by far the most likely diagnosis. In his last x-ray report, he included the possibility of 0/1 profusion of small nodules, but still favored tuberculosis.

Dr. Wheeler stated that in his experience, unprotected drillers who worked during and before World War II were the most likely to develop silicosis and large opacities; generally large opacities are central in both lungs, not far from the hila, and bilateral.

Dr. Bruce N. Stewart

Dr. Stewart reviewed medical records, and provided a report dated November 1, 1999 (DX 50). He concluded that the medical evidence supported a diagnosis of simple pneumoconiosis. He noted that although tuberculosis was an alternative explanation for the x-ray abnormalities, they are also compatible with pneumoconiosis. He agreed with Dr. Castle and Dr. Jarboe on the issue of complicated pneumoconiosis. In his opinion, the Claimant did not have any significant pulmonary or respiratory impairment, and could return to his previous coal mining work.

Dr. Stewart reviewed additional records, and provided a report dated July 10, 2001 (EX 5). It remained his opinion that the Claimant has simple pneumoconiosis, but that there is not sufficient evidence for a diagnosis of complicated pneumoconiosis. He continued to feel that the Claimant does not have any significant pulmonary or respiratory impairment, and is not totally and permanently disabled to perform his previous coal mining work.

Dr. Stewart reviewed additional medical records, and provided a report dated May 22, 2002 (EX 22). He again concluded that there was sufficient evidence to justify a diagnosis of simple pneumoconiosis, but that there was no evidence of a pulmonary or respiratory impairment, and the Claimant would be able to return to his previous coal mining work.

Dr. Kimberly Jones

Dr. Jones examined the Claimant on December 5, 2001 (CX 7). She noted his coal mine work history, as well as his previous smoking history. The Claimant did not have a family history of tuberculosis. On examination of the Claimant, she found that his chest expansion and diaphragmatic excursions were normal, and breath sounds were moderately reduced. There were no rales, rhonchi, or wheezes. She cited to the x-ray interpretation by Dr. Patel, indicating pneumoconiosis 2/2, q, t, in all lung zones, with coalescence of small opacities in the upper lung zones and poorly detailed non calcified, ill defined Category B large opacities in the upper lung zones. Dr. Jones noted that the Claimant had a significant history of exposure to coal mine dust, and extensive x-ray abnormalities consistent with complicated pneumoconiosis, Category B, as a consequence of his coal mine employment. Dr. Jones felt that the Claimant was unable to work in any dust.

DISCUSSION

In order to establish a material change in conditions, the Claimant must establish that he is totally disabled due to pneumoconiosis.[7] Although the Employer contests the issue of the existence of pneumoconiosis, the Employer also concedes in its Brief that a significant majority of the x-ray interpretations are positive for simple pneumoconiosis, and all of the pulmonologists who

[7] Again, as the Director has not contested any issues, the question of whether the Claimant is totally disabled due to pneumoconiosis is essentially moot. I make these findings in the alternative, in the event that it is ultimately determined that Robinson Phillips is the responsible operator.

have examined the Claimant or reviewed his medical records have concluded that he has simple pneumoconiosis, and thus, "undoubtedly, substantial evidence can support a determination that the Claimant contracted simple coal workers' pneumoconiosis in the course of his coal mine employment." Employer's Brief at 9. Indeed, considering the overwhelming preponderance of positive x-ray readings, as well as the almost unanimous medical opinions on this issue, I find that the Claimant has established that he has pneumoconiosis.

The pulmonary function and arterial blood gas study results do not establish presumptive disability under Section 718.204(c), and indeed have been uniformly interpreted as normal. In addition, all of the physicians who have examined the Claimant or reviewed his medical records have concluded that he does not have a pulmonary impairment, much less a totally disabling pulmonary impairment.

However, there is evidence that raises the question of whether the Claimant has complicated pneumoconiosis, and thus is entitled to the irrebuttable presumption of total disability due to pneumoconiosis, as provided by Section 718.304. The physicians engaged by the Employer, while in agreement that the Claimant has large masses or areas of coalescence in his lungs, do not agree that those masses or areas of coalescence represent complicated pneumoconiosis

In *Eastern Associated Coal Corporation v. Director, OWCP*, 220 F.3d 250 (July 12, 2000), the Fourth Circuit discussed the three different ways set forth in the statute to establish the existence of statutory complicated pneumoconiosis in order to invoke the irrebuttable presumption, and noted that in applying the standards set forth in each prong,

> [O]ne must perform equivalency determinations to make certain that regardless of which diagnostic technique is used, the same underlying condition triggers the irrebuttable presumption.

Id. at 255, 256, *citing Double B Mining, Inc., v. Blankenship*, 177 F.3d 240, 243 (4th Cir. 1999).

Additionally, the Court stated that

> "[B]ecause prong (A) sets out an entirely objective scientific standard" –i.e. an opacity on an x-ray greater than one centimeter –x-ray evidence provides the benchmark for determining what under prong (B) is a "massive lesion" and what under prong (C) is an equivalent diagnostic result reached by other means.

Id. at 256, citing Double B Mining at 243.

Although the Court acknowledged that a finding of statutory complicated pneumoconiosis may be based on evidence presented under a single prong, the Court also noted that the ALJ must review the evidence under each prong for which relevant evidence is presented, to determine if complicated pneumoconiosis is present. The Court stated that:

> Evidence under one prong can diminish the probative force of evidence under another prong if the two forms of evidence conflict. Yet, "a single piece of relevant evidence," *Lester [Lester v. Director, OWCP], 993 F.2d at 1145,* can support an ALJ's finding that the irrebuttable presumption was successfully invoked if that piece of evidence outweighs conflicting evidence in the record.

Id.

As the Court noted, even if there is some x-ray evidence that indicates that there are opacities that would satisfy the requirements of prong (A), if there is other x-ray evidence available, or other evidence relevant to an analysis under prongs (B) or (C), then all of the evidence must be considered to determine whether the evidence as a whole indicates a condition of such severity that it would produce opacities greater than one centimeter in diameter on an x-ray. The Court stated:

> Of course, if the x-ray evidence vividly displays opacities exceeding one centimeter, its probative force is not reduced because the evidence under some other prong is inconclusive or less vivid. Instead, the x-ray evidence can lose force **only if other evidence affirmatively shows** that the opacities are not there or are not what they seem to be, perhaps because of an intervening pathology, some technical problem with the equipment used, or incompetence of the reader.

Id. (emphasis added).

The Fourth Circuit discussed the statutory definition of "complicated pneumoconiosis," noting that it is not congruent with a medical or pathological condition. The Court noted that the statute creating the irrebuttable presumption of causation does not refer to the condition as "complicated pneumoconiosis," or to a medical condition that doctors have independently called complicated pneumoconiosis. As the Court stated

> [T]he presumption under § 921(c)(3) is triggered by a congressionally defined condition, for which the statute gives no name but which, if found to be present, creates an irrebuttable presumption that disability or death was caused by pneumoconiosis. . . . In short, the statute betrays no intent to incorporate a purely medical definition.

*Eastern Associated Coal Corporation,*250 F.3d at 257.

Thus, if the Claimant meets the congressionally defined condition, that is, if he establishes that he has a condition that manifests itself on x-rays with opacities greater than one cm., he is entitled to the irrebuttable presumption of total disability due to pneumoconiosis, unless there is affirmative evidence that persuasively establishes either that these opacities do not exist, or that they are the result of a disease process unrelated to his exposure to coal mine dust.

Evidence under Prong (A)

There is new x-ray evidence of opacities that would satisfy the requirements of prongs (A), in the form of the ILO interpretations by Dr. Forehand and Dr. Cole (February 3, 1998), Dr. DePonte (July 3, 1999 and November 30, 2001), Dr. Robinette (November 5, 1999), and Dr. Patel (July 13, 2001). However, there is also other x-ray evidence in the record that is relevant to an analysis under prong (A), and thus all of this evidence must be considered to determine whether the evidence as a whole indicates a condition of such severity that it would produce opacities greater than one centimeter in diameter on an x-ray.[8]

Dr. Wheeler, who reviewed the newly submitted x-rays, found them negative for pneumoconiosis, and concluded that the large masses in the Claimant's lungs were caused by tuberculosis. However, there are several aspects of his findings that cause me to place diminished reliance on his interpretations.

Dr. Wheeler reviewed a number of the Claimant's x-ray films. While he conceded that some of the nodules seen on the Claimant's x-ray could be silicosis, he felt that tuberculosis was by far the most likely to follow the pattern of the Claimant's x-rays. Indeed, he stated that in his opinion, the Claimant had tuberculosis until proven otherwise.[9] However, the overwhelming majority of the physicians who have interpreted the Claimant's x-rays have concluded that he has simple pneumoconiosis, and I have also found, based on the x-ray interpretations as well as the medical reports, that the Claimant has pneumoconiosis. In one of his later opinions, Dr. Wheeler stated that while he earlier thought that some of the small nodules might have been pneumoconiosis, the fact that they later evolved into a mass like appearance convinced him that they were much more likely to be granulomatous disease. This statement does not make sense - is Dr. Wheeler saying that nodules of pneumoconiosis cannot evolve into a mass like appearance? If so, what is his basis or rationale for such a statement? Dr. Wheeler provides no explanation for this baffling statement.

As early as the November 1991 x-ray, Dr. Wheeler noted the presence of a possible two centimeter mass or pleural fibrosis in the Claimant's right upper lobe, and a one to two centimeter mass in the left apex. Based on the location of these masses, he felt that they were far more likely to be tuberculosis, and again, that they were conglomerate tuberculosis until proven otherwise. He also relied on his experience, which showed that patterns of silicosis and pneumoconiosis stabilize once exposure ceases, and if a mass develops then something else, such as cancer, active tuberculosis, or other infection should be considered. Of course, this ignores the well established concept that pneumoconiosis is a latent and progressive disease, that can develop and progress even after a miner leaves the mines.

Dr. Wheeler has conceded that the pattern of nodules on the Claimant's x-rays has evolved into a "mass like appearance." However, in the face of a total lack of evidence of any exposure to

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[8] There is no evidence in the record that falls under prongs (B) or (C).

[9] The Claimant has no history of exposure to tuberculosis, and no family history of the disease.

tuberculosis, and numerous readings of pneumoconiosis by other physicians, he has held fast to his opinion that these "mass like appearances" are "most likely" conglomerate granulomatous disease. In light of the overwhelming preponderance of x-ray interpretations and medical opinions to the contrary, I find Dr. Wheeler's attempts to discount the presence or role of pneumoconiosis utterly unconvincing.

I also note that the ILO form defines Category A, B, and C opacities in terms of the dimensions of these opacities, and thus requires that an opacity be designated as Category A, B, or C **solely** on the basis of the size of the opacity. However, while Dr. Wheeler found masses on the Claimant's x-rays, he did not attempt to properly classify them on the ILO form. Instead, he was at pains to explain that these masses were not complicated pneumoconiosis, although he was not able to make a definitive diagnosis. Apparently, Dr. Wheeler does not believe that the masses on the Claimant's x-rays qualify as "large opacities" because individual nodules are distinguishable within the masses. But this does not answer the question of whether they in fact appear on the x-rays as large opacities, regardless of whether Dr. Wheeler thinks they qualify as complicated pneumoconiosis in the medical sense of that term. I find that the x-ray interpretations by Dr. Wheeler do not provide affirmative evidence that there are no opacities that appear on the Claimant's x-rays, or that these opacities are due to a disease process other than complicated pneumoconiosis.

Dr. Scott reviewed the Claimant's x-rays, finding pneumoconiosis in the latest two, but noting no large opacities on the ILO form. On each of his readings, Dr. Scott noted the presence of an infiltrate, mass, or fibrosis in the right upper lung, which he felt was compatible with tuberculosis, pneumonia, granulomatous activity, or unknown activity. I find Dr. Scott's interpretations, which do not provide a diagnosis, but speculate about the disease processes that could be responsible for these large masses, do not provide affirmative evidence that there are no opacities on the Claimant's x-ray, or that they are due to a disease process other than complicated pneumoconiosis.

Dr. Hippensteel felt that, while some of the abnormalities on the Claimant's x-ray were consistent with simple pneumoconiosis, the non-eggshell partially calcified nodules were compatible with granulomatous disease. In his November 9, 2000 report, Dr. Hippensteel stated that the x-ray findings were not compatible with complicated pneumoconiosis, because they did not suggest a coalescence of small opacities into a large opacity. But when he reviewed the Claimant's July 2001 x-ray, Dr. Hippensteel **did** find axillary coalescence, in fact two areas of coalescence in the right upper lobe with a combined diameter of about 4 X 5 centimeters, and a 2 centimeter diameter area in the left apex. But instead of conceding that these areas of coalescence qualified as large opacities, he distinguished them as areas of close proximity of specific nodules, as opposed to conglomeration or development of a large opacity. Dr. Hippensteel's statements are confusing - while his earlier opinion suggests that a coalescence of small opacities qualifies as a large opacity, his later opinion suggests that is not enough, and the small opacities must merge and lose all individual characteristics. But none of these statements address the question of whether the disease process in the Claimant's lungs shows up on x-ray as large opacities, whether or not individual characteristics of the merged nodules are apparent, or the area is a solid mass. I find

that Dr. Hippensteel's opinions are contradictory and not well reasoned, and I am not persuaded by his attempts to explain away the findings on the Claimant's x-rays.

In addition, Dr. Hippensteel repeatedly stated that the Claimant did not have pulmonary function abnormalities to correlate with the development of complicated pneumoconiosis, whereas pulmonary impairment would be expected if he had complicated pneumoconiosis or progressive massive fibrosis. However, it is not necessary for a miner to establish any pulmonary impairment in order to qualify for the irrebuttable presumption under Section 718.304, and evidence that qualifies under (A), (B), or (C) of that section, absent affirmative evidence that the large opacities are not there, or are the result of another disease process, is sufficient to invoke the presumption, even in the absence of pulmonary impairment. I find that Dr. Hippensteel's opinions are not well-reasoned, and ignore the statutory concept of complicated pneumoconiosis.

Dr. Dahhan reviewed the Claimant's newly submitted x-ray films, and concluded that they showed simple pneumoconiosis, but that there was no evidence of complicated pneumoconiosis or massive pulmonary fibrosis. He relied on the normal clinical examinations of the Claimant's chest, and the normal pulmonary function study results, as well as the "negative" x-ray readings by the majority of interpreters. Again, under the regulatory scheme, a respiratory impairment is not necessary for a finding of complicated pneumoconiosis. Dr. Dahhan relied heavily on the opinions by the physicians at Johns Hopkins (i.e., Dr. Wheeler and Dr. Scott), who found no abnormality of complicated pneumoconiosis on x-ray. But he provided no independent analysis of the large masses found by both of these physicians on the Claimant's x-ray. He also relied on their reading of the Claimant's chest CT scan, when there is no such evidence in the record. I find that Dr. Dahhan's opinions are not well-reasoned or supported, and do not provide affirmative evidence that there are not large opacities on the Claimant's x-rays, or that they are due to another disease process.

Dr. Castle also reviewed the Claimant's new x-rays; on each one, he found that there was axillary coalescence in the right upper lung zone, but no opacities. With respect to the 1998 x-ray, he stated that the area of axillary coalescence was not a large opacity because individual nodularity could easily be distinguished, and thus it was not progressive massive fibrosis. According to Dr. Castle, an axillary coalescence is a coming together of nodules that remain individual, but do not form a large opacity. He agreed with Dr. Wheeler, that there was no evidence of complicated pneumoconiosis by radiologic or physiologic testing, noting that a Category B opacity would "very, very likely" result in some degree of functional abnormality. Again, I find that the distinction between a mass comprised of coalescing nodules and a mass that is solid is not relevant to the question of whether the mass in fact appears on x-ray as a large opacity. As did Dr. Wheeler and Dr. Hippensteel, Dr. Castle felt that if the masses represented complicated pneumoconiosis, the Claimant would "very, very likely" have functional impairment. Again, a finding of entitlement to the presumption at Section 718.304 does not depend on the presence of functional impairment, or a diagnosis of complicated pneumoconiosis in the clinical sense.

Dr. Kim also found pneumoconiosis in the last x-ray he reviewed, but he did not note any large opacities. On each of his readings, however, he also noted an infiltrate, focal density, or

fibrosis in the right upper lung, that was suggestive of a granulomatous process, unknown activity, or pneumonia. Dr. Repsher, who reviewed the November 30, 2001 x-ray, found pneumoconiosis, but noted no large opacities. He did find scarring in the right upper lung and hemidiaphragm, which he felt was atypical for pneumoconiosis, but could be old granulomatous disease. Dr. Scatarige reviewed this same x-ray, finding pneumoconiosis but no large opacities. He noted an ill defined opacity, 3 X 4 cm., in the right upper lung, and a 1.3 X 2.4 opacity in the left apex, of unknown etiology, possibly tuberculosis, pneumonia, or cancer. In the absence of any medical evidence in the record that the Claimant contracted tuberculosis, that he had cancer, or pneumonia, I find that these interpretations, which do not provide a diagnosis, but merely speculate about the disease processes that could be responsible for the findings on the Claimant's x-rays, do not provide affirmative evidence that there are no opacities on the Claimant's x-ray, or that they are due to a disease process other than complicated pneumoconiosis.

As the remaining physicians, Dr. Jarboe, Dr. Stewart, and Dr. Spagnolo, did not review any x-ray evidence, but reviewed the medical reports of others, their opinions do not fall under any of the prongs of Section 718.304, and thus I do not consider them as affirmative evidence that the Claimant does not have large opacities or massive lesions in his lungs. I do note that all of these physicians acknowledge the presence of the large masses in the Claimant's lungs, although they do not agree that they are due to complicated pneumoconiosis. Nevertheless, they are not able to do more than speculate about the causes of these masses.

I find that the Claimant has established that he has opacities on x-ray that meet the requirements of Section 718.304, and that there is no affirmative evidence that persuasively establishes that these opacities are not there, or that they are due to a disease process other than pneumoconiosis. Thus, the Claimant has established that he is totally disabled due to pneumoconiosis, which is a material change in conditions since the January 1995 denial by the Director. As the Claimant worked for over ten years in the coal mines, he is entitled to the statutory presumption that his pneumoconiosis arose out of his coal mine employment, a presumption that has not been rebutted.

CONCLUSION

I find that the Claimant has established that he has complicated pneumoconiosis pursuant to Section 718.304, that arose out of his coal mine employment, and thus he is entitled to benefits under the Act.

ORDER

It is hereby ORDERED that the claim of Foster R. Addair for benefits under the Act is GRANTED. It is further ORDERED that the Black Lung Disability Trust Fund shall pay to the Claimant all benefits to which he is entitled under the Act .

A

LINDA S. CHAPMAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601,Washington, D.C. 20013-7601. *A copy of a Notice of Appeal must also be served on the Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2605, Washington, D.C. 20210.*